# ADDITIONAL INQUIRIES

**To Seller:**

11. As to the proposed distributions numbered 2 through 4 listed in CMC's proposal for use of net closing proceeds, did the Board contact entities other than the University of Montana concerning the allocation of funds for health and healthcare programs that would benefit people in the CMC service area?

    a. Describe each of those contacts and the other programs considered by the Board.

    b. Did the Board distribute a request for proposals (RFP) or other documentation, seeking applications? If so, how was the RFP distributed? To whom was it distributed?

    c. What criteria were used to select the University of Montana or its Foundation?

**Response to Seller Question No. 11:** With regard to the distribution number 2 in the proposal, this distribution proposes a Ten Million dollar gift to the University of Montana Foundation for the benefit of the University of Montana to help capitalize expansion of the Skaggs Building on Campus, to help capitalize the creation of an educational program for health professionals, and to endow loan forgiveness type scholarships for health professional students at the University of Montana which will provide incentives for those professionals to remain in CMC's former service area. The health professions at the University that would benefit from the expansion of the Skaggs building would include a new proposed Physician Assistant Program and the Western Montana Family Practice Residency Program ("WMFPR"). The only entity in the service area capable of operating a graduate program in mid-level clinician studies is the University of Montana. The only sponsor organization for the WMFPR Program within the service area is the University of Montana College of Health Professions and Biomedical Sciences (other than Community Medical Center and St. Patrick Hospital). There are therefore no other potential recipients for this proposed distribution.

At the time of the first consideration of this proposal, the Board had other proposals under consideration. The Board empanelled a task force to review and evaluate proposed uses of the sales proceeds. The Task Force was made up of members of the CMC Board and the CMC Foundation Board ("CMCF"). It began analyzing the post-closing mission and structure of CMC, CMCF and any new or existing foundation or nonprofit organization that was to be a recipient of sales proceeds. See: Exhibit 11-A, CMC Post Closing Mission and Structure, Draft of May 13, 2014, objectives of the task force.

The Task Force was considering proposals received in response to informal requests for proposals. The proposals at that time included an education initiative, a research initiative, and an initiative to help with patient affordability. The Task Force held a meeting on or about May 16, 2014, to discuss these initiatives and other post-closing issues, such as who holds the right of first refusal, what restrictions shall there be on use of proceeds, etc. The Task Force then heard from representatives of some initial program initiatives. The Task Force did not consider these

initial discussions exhaustive, but rather preliminary proposals of the kind that could be considered for funding from the proceeds of the sale as no request for proposals had been distributed.

Dr. Patrick Beatty presented a proposal for funding basic cancer research. See: Exhibit 11-B, Community Clinical Research Center. Some questioned the direct benefit of a pure cancer research program, and whether such a program might find funding from pharmaceutical companies. The University of Montana, through its president, Royce Engstrom, and the future Dean of the College of Health Professions Reed Humphrey, presented its proposal for training of new health care professionals, specifically a Physician Assistant Program. See: Exhibit 11-C, Letter from President Engstrom with attached slides from his presentation. Some questioned whether the U of M proposal could be better focused on training of Nurse Practitioners, and whether the focus of an education program at the U of M could be limited geographically to the service area of CMC. A proposal was submitted for an expansion of housing available at the Ronald McDonald House, and to endow assistance for patients that could not afford care. See: Exhibit 11-D, Proposal for Housing/Patient Affordability Support. Some questioned support for the Ronald McDonald house, as it is located near CMC, and might be seen as support for the facility there, to the exclusion of other worthy programs. Some questioned whether the contribution toward patient affordability could be meaningful given the scope of the problem and the limited funds available.

None of the proposals were rejected, but the proposals for Housing/Patient affordability and for Clinical and basic research were rather taken under advisement for consideration by the new foundation, as support for these programs could be funded from the endowment. It was determined that the proposal from the University of Montana needed to be handled differently, as capitalization of those programs could not be funded from the endowment, and would have to be authorized as a separate grant. In discussions with the existing Foundation, described below, the Board determined that consideration of other worthy programs should be deferred until the new foundation was created, and those programs and their funding could be addressed more completely and systematically there.

The University of Montana proposal was the subject of much discussion and revision. The result is attached to the CMC Proposal for Use of New Closing Proceeds. The principal criteria used for the selection of this proposal were the robustness of the proposal, the lack of any other entity capable of starting such programs, the fact that the University of Montana is already a sponsor of the residency program, and most importantly, the Montana Healthcare Work Force Strategic Plan of 2011.

With regard to Uses numbered 3 and 4, those uses are largely administrative and dictated by legal and tax considerations. As ultimately directed by the AGO, the amount of $21.5M will be held at the CMC Missoula, Inc. level to account for any post-closing liabilities and to meet the APA's net worth requirement, until CMC Missoula, Inc. and the AGO determine it is appropriate and prudent to transfer the funds to the new Community Hospital Legacy Foundation.

12. As to the proposed distribution to the Community Hospital Legacy Foundation, did the Board consider transferring the funds to an existing foundation(s) or nonprofit organization(s)?

a. Describe the Board's process for considering an existing foundation(s) or nonprofit organization(s).

b. Identify the existing foundation(s) or nonprofit organization(s) that the Board considered.

c. Describe the Board's deliberative process and provide its reasoning in deciding to create the new Community Hospital Legacy Foundation, rather than distribute the funds to an existing foundation(s) or nonprofit organization(s)?

**Response to Seller Question No. 12:** The Board considered numerous alternatives including the creation of a new foundation, utilization of the existing Community Medical Center Foundation, the Montana Community Foundation, and the Montana Healthcare Foundation. In April of 2014, as negotiations concerning the conversion went forward, the Board began to discuss what needed to be done that would not be handled in the sale transaction. Some of the first discussion on the issue of creation of a new foundation versus using an existing foundation are in the email from Board member R. Phillips to Board Chair Stearns, Vice Chair Hacker and CEO Carlson. See: Exhibit 12-A, April 24, 2014. Thereafter, the process followed by the Board is represented in the minutes of the Board meetings of both the CMC and CMCF boards. The criteria used by the Board in making these decisions are included in a message from Robert Phillips to Board Leadership (Scott Stearns, Scott Hacker, Jan Parks) regarding a meeting between Phillips and Hacker, both members of the Task Force mentioned above, dated July 2, 2014. See: Exhibit 12-B.

Initially, the proposal was to create a new foundation and that is how the initial draft of the APA read. The Board considered a number of alternatives before completing its final proposal in mid-December, 2014.

1. Montana Health Care Foundation. The Board discussed utilizing the MHCF as a vehicle in July of 2014. Board Members of both that foundation and Caring for Montanans Inc. were contacted, and materials were reviewed. That Foundation made a presentation to the CMC Foundation, at which CMC board members were present later in 2014, and a proposal was made for receipt of the sales proceeds. The CMC Board also received a presentation by the MHCF. Following that presentation, the Board discussed using that foundation as a vehicle. Some commented that the MHCF had a very strong board of directors, although no CEO (at that time). The investment policies of that entity seemed robust, and the purposes very similar. Some questioned whether a foundation with statewide coverage and located in Bozeman could focus on the former service area of CMC. Some were concerned with the time and money that had been spent getting up and running, and some were concerned that some of the proceeds of BC/BS were still tied up in litigation against the Caring for Montanans entity. This could have delayed putting the funds to work right away, although the fact that it was already exempt from tax and qualified under 501(c)(3) was a positive element. It was felt that if the CMC Board went with a new foundation, or if it took a long time to be

ready to receive the funds, that CMC should consider using the MHCF as a vehicle in the future. This is still a consideration today.

2. Montana Community Foundation. The Board of CMC as well as the Board of CMC Foundation considered the Montana Community Foundation as a vehicle as well. Both boards received materials, and reviewed websites of this foundation. This Foundation was felt not to be as sophisticated as the MHCF or the University of Montana Foundation, and it has no specified purpose. It has no funds that approach the size of the one we needed. The average fund size at the MCF was quite small. It administers many different funds for many different organizations. It was not at all clear how much independence the board of our fund would have, or if the purpose of our fund could remain inviolate. The MCF could have put the funds to work quite quickly, but did not have the oversight we felt was needed. This is a very reputable and valuable organization for the small foundation, but not appropriate for a larger one.

3. The University of Montana Foundation. This foundation was felt to have excellent investment policies, board of directors and investment committee. It was prepared to change its purpose to include the "Triple Aim". It would have been up and running from day one, with little additional cost. The Board felt that this was perhaps the best alternative, but was objected to by the Attorney General, so the Board made the decision to not use it as a vehicle for the endowment funds.

4. The Community Medical Center Foundation. The CMC Board considered using the Foundation as a vehicle for receiving the proceeds. This Foundation did not feel that it had the infrastructure to undertake receipt of this large endowment, and the Board agreed. There was the added complication that donors to CMC Foundation needed to be approached concerning a new purpose for their gifts or pledges payable. Ultimately, the Board of the CMC Foundation elected to go its own way.

5. Other Foundations/Nonprofits. CMC has been approached by many foundations and non-profit organizations, none of whom have the necessary focus on our service area, and none of whom have the sophistication needed for management of such a large endowment. Early on in the process, the Task Force mentioned above travelled to Spokane Washington to meet with representatives of Empire Health Care Foundation, a foundation newly created after a conversion of similar nature and size in Eastern Washington. This impressive and effective foundation had accomplished much even though newly created. It continues to be a resource for CMC and our proposed new foundation. The Task Force members that became familiar with this foundation made the creation of a new and effective foundation seem entirely feasible. Based upon issues with all of the other potential foundations, it was decided that the creation of a new company would be the best alternative for fulfilling CMC's mission for a long time.

# EXHIBIT 11-A

# CMC Post-Closing Mission and Structure

DRAFT 5/13/14

## Broad Objectives

1. Define the mission for the use of the sales proceeds and any restrictions on their use
2. Establish the role, structure and governance of the post-closing entities, including:
    a. New Foundation
    b. Existing CMC Foundation (likely merged with New Foundation or becomes New Foundation)
    c. Existing Hospital Corp.
    d. Post-Closing Hospital Advisory Board
    e. CMC Representation on JV and BC Boards

## Timeline & Tasks

May Board Meeting:

1. Present outline of mission and structure
    a. Obtain consensus for the drafting AG Submission
    b. Obtain feedback on preliminary structure
2. Summarize potential UM involvement
3. Summarize next steps in assessing research feasibility
4. Summarize next steps in assessing mid-level education feasibility
5. Confirm Board's intent to purchase 2% JV interest

June Board Meeting:

1. Obtain Board's approval of AG Submittal unless received at May meeting

September 1, 2014 (Assumed Closing)

1. Complete formation and board population of new and repurposed entities

## New Foundation Mission

**Mission Objectives:**

1. Positively influence the health of Western Montana.
2. Establish lasting institutions or services rather than one time benefits.
3. Contribute to the economic vitality of CMC's service area.
4. Enhance Missoula's presence in the delivery of regional health care.

**Proposed Mission:**

The New Foundation's funds shall be restricted to the following uses:

1. **Post-secondary educational programs** for the purpose of training health care professionals focused on the delivery of primary care;
   ***[Note: Specific near-term intent is to establish a mid-level education program in coordination with UM. Drafting to be broad enough to provide flexibility to accommodate future changes in needs.]***

   *Questions*

   a. *Do we want to require UM to match funds provided by the New Foundation in order to leverage the New Foundation's resources and solidify UM's commitment?*
   b. *Can UM establish a nurse practitioner program in-lieu of a PA program?*
   c. *Will the program directly compete with Rocky Mountain College's PA program in Billings?*
   d. *What are the Western Montana benefits vs. the state-wide benefits?*

2. **Medical research** for the purpose of developing improved patient diagnoses, treatments or quality of care;
   ***[Note: Specific near-term intent is to establish a clinical research program with Missoula physicians related to oncology, pulmonology, rheumatology, diabetes, gastrointestinal and/or neurology. Need to determine if research should be in cooperation with UM or an existing research foundation or to establish a newly formed effort.]***

   *Questions:*
   a. *How does research benefit local patients?*
   b. *How do we establish a research effort so that it does not directly benefit one of the local hospitals?*
   c. *Do we work with an existing research effort?*
   d. *What level of staff would need to be established?*

3. **Housing/Patient Affordability (Ronald McDonald House)**

4. **Repurchase of CMC** pursuant to the terms of the sale agreement; and
5. **Other uses** benefiting the healthcare of patients or public health if either of the first [three] objectives is not reasonably feasible.

**Restrictions on Fund Uses:**

1. Funds cannot be used to fund activities which directly benefit CMC or St. Patrick Hospital.
2. Activities funded by the Foundation must be primarily performed in Western Montana.

*Question: How to define Western Montana?*

**Purchase of JV Interest:** As part of the formation transactions, the New Foundation shall purchase a two percent ownership interest in the Joint Venture pursuant to its option in the sale agreement.

Question:

Do the pros of ownership outweigh the cons?

Pros:

a. Strengthens Missoula area representative's voice on JV and BC Boards
b. Enhances Montana focus of JV, especially if Kalispell buys in
c. Facilitates enforcement of sale agreement through information received as an owner

Cons:

a. Is New Foundation truly separate from hospital if it owns a 2% interest?
b. Conflict of enforcing sale contract if also an owner
c. How will the AG view the ownership?

**New Foundation Life**: The New Foundation is intended to provide perpetual benefit to the community. Funds shall be invested and used with the intent of establishing and continuing mission services in perpetuity. Notwithstanding the foregoing, the New Foundation may dissolve its operations as described below.

**Ability to Contribute and Dissolve:** New Foundation may contribute funds to a third-party foundation so long as the use of such funds is restricted to those allowed in the New Foundation's mission. New Foundation may elect to dissolve upon the contribution of all funds.

***[Note: New Foundation has the option to contribute all its funds to a third party foundation (e.g., UM Foundation) under conditions and restrictions to be negotiated. New Foundation could be then dissolved.]***

*Question:*

*Can we get comfortable with the donation of the funds to a third-party foundation in the time we have prior to closing or should this be considered after the New Foundation is established for a portion or all of the funds?*

**New Foundation Board Composition**

The New Foundation's Board shall be an eleven member self-perpetuating community board initially consisting of: two members of the existing CMC Foundation Board; four members of the CMC Hospital Board; and five community members currently on neither board. Board members' terms shall be staggered three year terms. Neither employees of CMC or St. Patrick Hospital may be board members. ***[Note: Need to argue to the AG that current hospital and foundation board members are important to:***

***ensure execution of the mission which is being developed broadly and specifically by the Boards and to access the level of industry knowledge of the boards' members.]***

**Existing CMC Foundation**

The existing CMC Foundation's assets shall be merged with those received from the sale of the hospital's assets to form the assets of the New Foundation. The existing CMC Foundation's corpus may be used for the New Foundation or a new corpus established depending on IRS approval and legal issues. The New Foundation shall be responsible for winding down the obligations and on-going business of the existing CMC Foundation. The board of the existing CMC Foundation will be terminated with the formation transactions. Current employees of the existing CMC Foundation are eligible for employment with the New Foundation at the discretion of the New Foundation's Board.

**CMC Hospital Board**

The existing CMC Hospital Board shall be reduced in size from its current thirteen members to three members at the time of the formation transactions. The purpose of the board shall be to: a) unwind the remaining assets and liabilities of the existing hospital's corpus; and b) enforce the terms of the sale agreement. ***[$3.0 million TBD in Definitive Agreement]*** of proceeds from the sale of the hospital's assets shall remain in the hospital's corpus for the purpose of performing its duties. Any time after the [fifth] anniversary of the formation transactions, the CMC Hospital Board may terminate its activities if it determines that all of its obligations have been fulfilled. Any remaining assets shall be transferred to the New Foundation and the New Foundation shall assume responsibility to enforce the sale contract.

Question: Should the Hospital Board members be paid?

**Joint Venture and Billings Clinic Boards**: The New Foundation shall appoint one of its board members to each of the Joint Venture and Billings Clinic's Boards. The same board member may be appointed to both boards.

*Question: Scott Stearns suggested that a non-Board member be the representative of the board. Can a New Foundation Board member sit on these boards?*

**Post-Closing Hospital Advisory Board:** The New Foundation Board shall have the right to appoint one of its members to the Hospital Advisory Board to be formed by the Joint Venture as part of the formation transactions for so long as the New Foundation holds an ownership interest in the Joint Venture or [ten years], whichever is longer. ***[The purpose of the board seat is to monitor the New Foundation's investment and to monitor compliance with the sale agreement.]***

Question: Can the sale agreement be modified to accommodate this?

# EXHIBIT 11-B

UNIVERSITY OF MONTANA
umt.edu

HAND DELIVERED

May 19, 2014

Bob Phillips
Phillips Law Firm
283 West Front Street
Missoula, MT 59802
phillips@montana.com

Dear Bob,

Thank you for the opportunity to share our vision as to how the University of Montana would invest in health care education, research and community engagement if provided the benefit associated with the sale of Community Medical Center. Our collective intent was to leave you with at least four important messages:

1. The University of Montana in Missoula is home to a portfolio of vibrant, fully accredited health care programs within the College of Health Professions and Biomedical Sciences and the Missoula College. Enrollments are strong and the applicant pool deep. The depth and breadth of these programs and the regional recognition that derives from placement of our alumni illustrates that UM is the lead institution in health care education and complementing the strong health care systems in western Montana. That said, we are vigilant to forces that drive enrollment and quality and are continuously engaged in assessment and program improvement.

2. Effective fiscal management – The University has a well-established history of growing resources through strategic leveraging of extramural funding (recall from our presentation that our two COBRE funded centers in the College of Health Professions and Biomedical Sciences have leveraged initial funding of about $22 million to obtain over $50 million of additional non-COBRE funding).

3. Economic impact – The College of Health Professions and Biomedical Sciences has created over 100 jobs in the Skaggs research wing · built by local firms largely through private gifts and bonds associated with extramural funding – and spun off 5 companies through the COBRE centers. It is expected that new academic programming in the College would create, at minimum, at least 10 new positions and upwards of 30 new graduate students. With the creation of new undergraduate initiatives in the pre-health professions there is the potential to increase the undergraduate population by several hundred students. Moreover, expansion of classroom and research space would create local economic opportunity via planning and construction.

4. Community engagement – From K-12 programs like the Brain Zone to after-school programs like LEAP, the University is actively engaged with the Missoula community to create a healthier and more vibrant environment. It is anticipated that new initiatives like the Neural Injury Center, in concert with our current clinical relationships in both research and service (the pro bono PT clinic and New Directions, for example) will create new and deeper outreach opportunities between the University and the Missoula community and the surrounding region.

The demographics of health care clearly point to new but also expanded programs to train health care professionals, and the University is poised to move that expansion forward. As we discussed, the addition of a mid-level practitioner program would be an important and logical next step with the consideration of expansion of other programs where disparities exist or are forecasted for growth. We believe that in the context of our programs and the assessment of options, the addition of a Physician's Assistant program is the next vital step in meeting the growing needs in health care and look forward to meeting that need. Considering we seek the best students, we need endowed scholarships, taught by some of the best faculty, who will also need subsidies, and a contemporary facility with extensive instrumentation and programmatic experience built in that will also support other health programs and initiatives.

Our request is to consider a reinvestment of resources well beyond the proposed step of a new academic program so that all of the health profession programs can move assertively forward and further engage the Missoula community in an impactful manner. That level of investment was illustrated in the presentation in proportion to what we consider a truly transformational opportunity.

We would like to leave you with the request that you consider the transformational opportunity that would come with a significant strategic reinvestment of the CMC resources in the University and its health care mission. Rarely, if ever, does such an opportunity avail itself as this has, and you can rest assured the University has the people, enthusiasm and commitment to grow that reinvestment in ways that will honor the original intent of providing contemporary health care through education, research and community involvement. We believe the University of Montana Foundation is the logical money manager of choice. Our ability and sophistication of money management will help to ensure the type of integrity and returns that will steward this endowment well.

Thank you again.

Respectfully,

Royce C. Engstrom
President
University of Montana

Reed Humphrey, PT, PhD
Professor and Chair
School of Physical Therapy and Rehabilitation Science

Shane Giese
President and CEO
University of Montana Foundation

RCE/rp
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UNIVERSITY OF MONTANA

## A Strategic Leader in Healthcare Education & Research

Royce Engstrom, PhD
President, University of Montana

Reed Humphrey, PT, PhD
Professor & Chair, School of Physical Therapy & Rehabilitation Science

Shane Sieve, President and CEO
University of Montana Foundation

MISSOULA

## And a Community Partner

MISSOULA COUNTY MONTANA

## An Overview

- Healthcare education at UM
- Research in healthcare and biomedical science at UM
- Investment, economic growth & community outreach
- Our next step: Mid-level care through a Physician's Assistant Program
- Meeting the need through strategic investment
- Conclusions and discussion

## The College of Health Professions & Biomedical Sciences

Skaggs School of Pharmacy

- Department of Pharmacy Practice
  - Pharmacy Doctorate
  - Geriatric Education Center
- Department of Biomedical & Pharmaceutical Sciences
  - Graduate programs in neuroscience, toxicology, medicinal chemistry, biomedical and pharmaceutical sciences
  - Centers for Structural & Functional Neuroscience, Environmental Health Sciences

## The College of Health Professions & Biomedical Sciences

School of Physical Therapy & Rehabilitation Science

- Doctorate of Physical Therapy
- The Nora Staael Evert Physical Therapy Clinic & New Directions Wellness Center
- The Neural Injury Center

## College of Health Professions & Biomedical Sciences

- School of Public & Community Health Sciences- MPH
- School of Social Work- BSW, MSW
- Family Medical Residency Program of Western Montana
- The Western Montana Area Health Education Center

## Missoula College Health Professions Programs

- Medical Assisting
- Pharmacy Technology
- Nursing
  - Practical Nursing
  - Registered Nursing
- Radiologic Technologist
- Respiratory Care
- Surgical Technology

## Investing in UM: The Centers of Biomedical & Research Excellence (COBRE)

## COBRE Program Impact

Point One – Investment in the research infrastructure grows people, expands the science of patient care and preventive health, and provides leverage for additional funding.

University of Montana
COBRE Center for Environmental Health Sciences

FY 1-10: Hired 6 new faculty

FY 5-10: COBRE Funding: ≈ $10,769,313
Leveraged non-COBRE Funding: ≈ $24,131,997

FY 1-5: 102 publications
FY 6-10: 176 publications

## COBRE Program Impact

Invest. Grow.
Benefit. Repeat.

University of Montana
COBRE Center for Structural & Functional Neuroscience

FY 1-10: Hired 7 new faculty

FY 5-10: COBRE Funding: ≈ $10,760,000
Leveraged non-COBRE Funding: ≈ $40,547,000

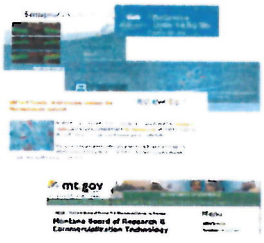
FY 1-5: 59 publications
FY 6-10: 148 publications

Point Two: New labs create new employment opportunities, allowing UM be an economic partner in the community, serving as a hub for additional growth

- **Strengthened Translational and Clinical Research Efforts with Regional Hospitals**
- **Additional recruitment beyond COBRE core hires**
  *CSFN has grown from 8 investigators to more than 40 statewide*
- **Development of New Space**
  *Presence of CSFN and CEHS drove the construction of a $20M research addition. ~ 80 employees*

## Economic Development, Job and Business Creation in Our Community

Invest. Grow.
Benefit. Repeat.




- **New State Support**
  *CSFN matching grant for economic development from the Montana Department of Commerce*
- **Greater Private Sector Collaborations**
  *SBIR Grants, shared use of 11 Core facilities*
- **Spin-off Companies**
  *5 New companies started out of CSFN and CEHS over past 5 years*

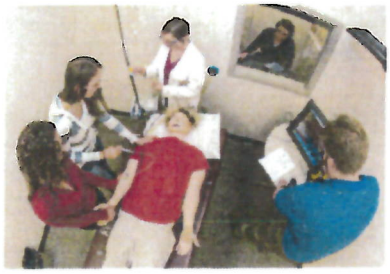
## Point Three: Investing in UM is in investing in the community's health & education

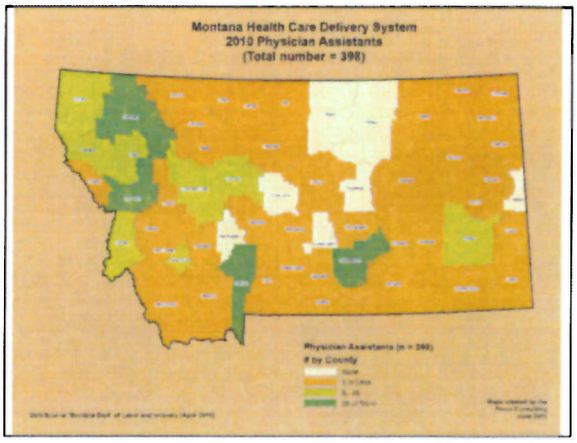
- K-12 Outreach
  - *CSFN R25-funded NINDS STEM Big Sky Brain Project*
  - *SpectrUM & The Brain Zone – Front Street (EPSCoR)*
  - *CEHS SEPA NIEHS Project Clean Air, Healthy Homes*
- Community service & research
  - Institutional partnerships
  - UMPT Pro bono clinic & the New Directions Wellness Center
  - UMPT LEAP
  - iPHARM
- Lectures & community presentations to increase scientific literacy; health awareness

## The Health Professions at the University of Montana: Looking to the Future

- Impact of the Affordable Health Care Act
- Addressing Health Care Workforce Needs

## Our Next Step: Physician's Assistant Program





## Demographics

- Presently 430 physician assistants in MT; Bureau of Labor Statistics projects that need to be 783 by 2018
- Demographics for physician assistants may underestimate the need, particularly by specialty or region (sources: Kaiser Foundation, Montana Healthcare Workforce Statewide Strategic Plan, 2011)
  - Location quotient is 1.43 for Missoula (1.49 MT) but 7 counties have no practicing physician assistants;
  - While Missoula county is one of four with the higher distribution of physician assistants, it does not reflect present or future community and regional need;
  - Employment by specialty: only 33% of practicing physician assistants are in primary care in MT versus 45% nationally.

## Benefits to Program Expansion

- Increasing the primary care mid-level providers for Missoula and the region, particularly for rural and underserved populations;
- Enhancement of existing campus programs in the health professions but particularly, the Western Montana Family Medical Residency Program;
- Increasing the undergraduate and graduate population, faculty and staff in the context of economic impact for the Missoula community;
- Attraction of external funding, both public and private, to support education, the research infrastructure, and experiential opportunities for students and community members on campus;
- The identification of Missoula and the University as the regional hub for the health professions.

## Example Program
## University of South Dakota

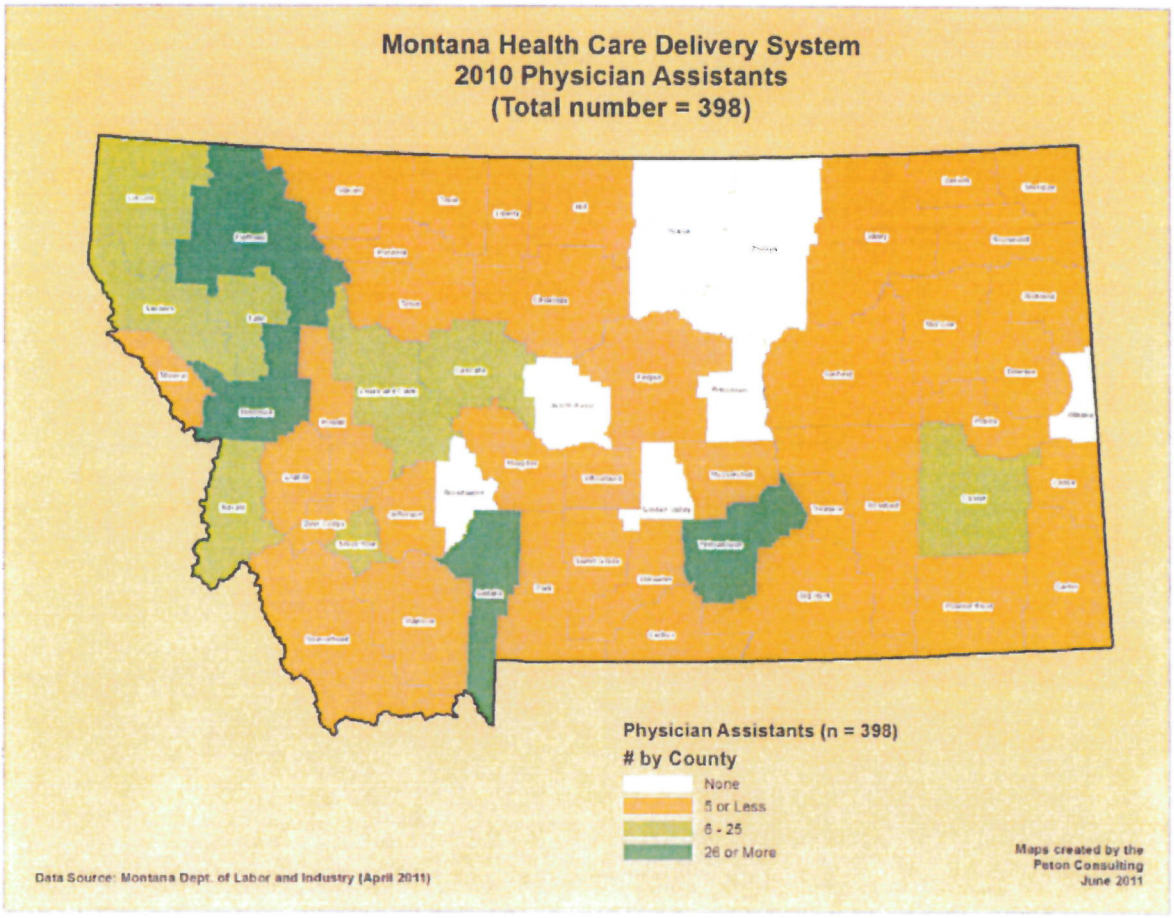
- ***CNN Money and U.S. News* ranks Physician Assistant as the Eighth Best Healthcare Job and the Thirteenth Best Job in the United States**
- **Components to program:**
  - **Didactic Phase**
  - **Clinical Phase**
- **20 students per year, 100% placement**
- Average starting salary for most recent graduates is $73,000 per year
- **Staffing: 7 faculty, 2 clinical support, 2 administrative**
- Accreditation Review Commission on Education for the Physician Assistant (ARC-PA)

An opportunity to reinvest in the community through higher education that is transformational.

## Physician Assistant

### Strategies

| Physican Assistant Strategies | Resources & Organizations | Measures & Outcomes |
|---|---|---|
| To increase confidence and skill levels of new PAs , and to expose potential recruits to the demands required in the rural/frontier position, support intern/residency programs and continuing education opportunities. | Rocky Mountain College, Medex (through U of Washington), Monida Healthcare Network, local CHCs, local healthcare facilities, AHECS | Number of students participating in rural residency programs, number of graduates accepting positions in rural facilities |
| Encourage supportive community involvement/partnerships in recruiting and retention efforts. | Local businesses, governments, healthcare facilities, MORH—CHSD | Track number of PAs recruited to rural and underserved location, track length of time in current position of the PA workforce |
| Maintain or increase financial incentive programs for practice in rural and underserved settings—NHSC, MT State Loan Repayment, private grants/scholarships. | DPHHS—PCO, SC AHEC | Number and dollar amount of financial incentives offered for rural practice |
| Develop systems for relief providers (locum tenens or respite pool) to allow for personal time for providers. | Health networks in MT, CHCs, local healthcare facilities | |



## Description

Physician Assistants deliver a broad range of medical and surgical services to diverse populations in rural and urban settings. They are health professionals who practice medicine as members of a team with their supervising physicians. As part of their comprehensive responsibilities, PAs conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive health care, assist in surgery, and prescribe medications. Physician assistants are certified by the National Commission on Certification of Physician Assistants and are also state-licensed. Nationally, about 45% of the PA workforce works in a primary care capacity. Employment of PAs is expected to grow by 39% from 2008 to 2018, with much faster growth than the average for all occupations (BLS projections). Growth projections reflect the expansion of healthcare coverage through healthcare reform and efforts made for cost containment.

## Overview

Physician Assistants play a crucial role in rural healthcare in Montana and are well-suited to improve access in rural locations. PAs often serve as the sole primary care provider for the community in locations that have difficulty recruiting physicians. Interestingly, Eastern Montana is one of the top paying nonmetropolitan areas in the country ($98,450 annual mean wage per May 2010 Occupational Employment and Wages report, BLS).

## Workforce

The Montana Physician Assistant workforce has shown significant growth since 2000, increasing from 150 to the current 398, an average annual growth rate of 15.16% (per DOLI). The Bureau of Labor Statistics projects that 783 PAs will be needed in Montana by 2018. The American Academy of Physician Assistants reports that about 33% of the practicing PAs in Montana were employed in a primary care capacity (family/general medicine, general internal medicine and general pediatrics) in 2009.

The Kaiser Foundation reports 41 PAs per 100,000 population in MT while the national figure is 24/100,000. The Location Quotient for PA's is 1.26, also suggesting an oversupply. We also know that seven counties in MT have no practicing PAs at all, while four counties have 26 or more, suggesting maldistribution of the PA workforce.

## Education and Training

There are 156 accredited PA training programs nationally. The only PA training program available in Montana (and the northern Rockies) is Rocky Mountain College in Billings. The Masters level program strives to excel as a center of health care education and is dedicated to providing medical services to the underserved and rural populations of the intermountain region. Administration at Rocky reports that about 25% of the incoming class of 33 is from Montana. Likewise, about 25% of graduates will stay in the state to practice upon graduation. It's also estimated that about 40% of grads will work in primary care upon completion of their program.

The Medex PA training program originated in 1970 and is offered through the University of Washington School of Medicine. The program is offered at three campus locations in Washington state (Seattle, Spokane and Yakima) and one in Alaska. Recent information indicates approximately 7% of the incoming class are students from Montana and approximately 16% of graduates will practice in a WWAMI state other than Washington.

The Monida Healthcare Network has received a grant to develop a six-month practicum experience for PAs specifically oriented to emergency care. Upon successful completion of the practicum, the PAs will be able to practice without on-site physician supervision. The initial project is slated for three hospitals in Western Montana. If successful, the program could be shared throughout the state.



# EXHIBIT 11-C

# Community Clinical Research Center

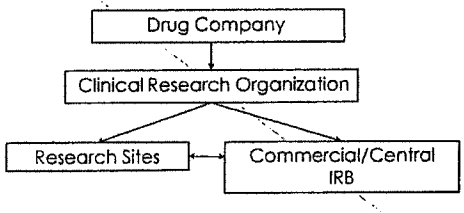
Patrick G. Beatty, MD, PhD

## Clinical Research

- What is it?
- How is it done?

2

## A New Promising Drug . . .




3

## Background

- Clinical Research Experience
  - 10 years Fred Hutch Cancer Research Center
    - Unrelated Bone Marrow Transplant
  - 10 years University of Utah
    - Bone Marrow Transplant
- Recruitment to Montana Cancer Specialists
  - School of Pharmacy
    - Vern Grund
    - Dave Forbes

4

## Montana Cancer Institute Foundation - Where have we come in the past 10 years

5

- Efficient, quality data collection and experience
  - Relationships with pharmaceutical companies

6

## Pharmaceutical Trials

| Ranking | Company | Revenue, US $billions (2012) | # of clinical trials |
|---|---|---|---|
| 1 | Roche | 45.77 | 13 |
| 2 | Amgen | 17.27 | 5 |
| 3 | Gilead Sciences | 9.703 | 2 |

- 29 companies
- 80 trials

7

## Genentech PDL-1

- Very active immune drug against lung cancer and likely other cancers

8

## Salivex Study

- Oral spray drug based on active ingredient of Marijuana

9

10

## Revenue from Pharmceutical Trials

- Assist other local research projects
  - **Pharmacogenetics of cancer drugs in Native Americans**
  - Spinoffs of Pharmacogenetics projects for the University of Montana
  - Komen Foundation Grants

11

12

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## Revenue from Pharmaceutical Trials

- Assist other local research projects
  - Pharmacogenetics of cancer drugs in Native Americans
  - **Spinoffs of Pharmacogenetics projects for the University of Montana**
  - Komen Foundation Grants

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- Helped Erica Woodahl become part of a U of W Grant "Pharmacogentics in Rural and Underserved Populations" $1,028,347 over five years to the U of M (Direct Costs)
  - Renewal application pending
  - Several new jobs in School of Pharmacy as a result

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## Revenue from Pharmceutical Trials

- Assist other local research projects
  - Pharmacogenetics of cancer drugs in Native Americans
  - Spinoffs of Pharmacogenetics projects for the University of Montana
  - **Komen Foundation Grants**

16

- Komen Foundation
  - 3 sequential grants, totaling $68,000: Cancer disparities in Native American populations, identify barriers to breast health in Native American Population

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## Education

- Students from School of Pharmacy
- Spectrum at U of M: Encourage careers in Biomedicine

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## The Opportunities . . .

- Expand cancer research
- Expand into other subspecialties
- Expand education

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## Expand Cancer Research

- Increase number of Cancer Pharmaceutical trials with more staff
- Expand participation in National Cancer Institute sponsored Cooperative Group Trials
- Consider expanding into research on Continuum of Care Delivery
- Very long range: New drug trials, based on U of M drug discovery

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## Expand into other Subspecialities

- Rheumatology (Lupus)
- Endocrinology (Diabetes)
- Neurology (Mulitiple Sclerosis)
- Other

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## Expand Education

- Help School of Pharmacy recruit a new faculty member focused on clinical research, to be based part time on current Community Medical Center Campus
- Develop formal training for School of Pharmacy students in Clinical Pharmacology Research
- More outreach to local communities on cancer related issues, other diseases as Research Center develops

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## Funding

- How do we get there?

23

## Start up costs

| Expense | Cost |
|---|---|
| Computers | $8,000.00 |
| IT/Data | $3,500.00 |
| Furniture/Exam Equipment | $65,000.00 |
| Office Supplies | $5,000.00 |
| Patient Supplies | $5,000.00 |
| Lease for space/storage* | $50,000.00 |
| Contingency | $30,000.00 |
| Total | $166,500.00 |

*Space cost will be dependant upon location and costs for capital construction/remodeling are not included.

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## Costs To Grow and Sustain

| Position | # of Employees | Annual Salary | Total Salary |
|---|---|---|---|
| Manager/Director | 1 | $78,000.00 | $78,000.00 |
| Lead Research Coordinator | 1 | $50,000.00 | $50,000.00 |
| Clinical Research Coordinator | 2 | $46,300.00 | $92,600.00 |
| Nurse | 2 | $60,000.00 | $120,000.00 |
| Administrative Assistant | 1 | $31,200.00 | $31,200.00 |
| Accountant | 1 | $45,000.00 | $45,000.00 |
| Pharmacology Faculty Member | 0.5 | $50,000.00 | $25,000.00 |
| Medical Director | 0.2 | $400,000.00 | $80,000.00 |
| Benefits | .25 | | $130,450.00 |
| Subtotal | | | $652,250.00 |

| Expense | Yearly |
|---|---|
| Travel and Education | $15,000.00 |
| Dues and Subscriptions | $500.00 |
| Repair and Maintenance | $15,000.00 |
| Medical Supplies | $10,000.00 |
| Lease for space/storage | $50,000.00 |
| Cleaning | $24,000.00 |
| Subtotal | $114,500.00 |
| Total | $766,750.00 |

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## Conclusions

- Expand treatment options for patients in the Missoula area, bring in cutting edge medicines
- Expand programs at U of M by allowing access to clinical research patients/samples
- Develop new, high paying jobs (Research techs, Research Coordinators, new faculty at U of M)
- Expand education in general community about cancer and other diseases

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# EXHIBIT 11-D

COMMUNITY MEDICAL CENTER FOUNDATION
PROPOSAL FOR HOUSING/PATIENT AFFORDABILITY SUPPORT
MAY 16, 2014

## I. BACKGROUND

It is not uncommon for patients to drive up to 100 miles one way to receive cancer treatment. Undergoing cancer treatment is emotionally, physically and financially draining - - both for the patient and the caregiver.

The American Cancer Society, a partner at Community Cancer Care, previously provided a service where they would obtain housing for cancer patients (and one caregiver), who live 50 miles away or 90-minutes from the Center. This service recently became burdensome when the American Cancer Society centralized their lodging call center in Texas.

In an attempt to help eliminate patient and caregiver financial stresses, Foundation Staff have been meeting with lodging facilities (hotels/motels/senior residences/apartment complexes) in Missoula and asking them to consider partnering with the Foundation in providing housing to cancer patients and one care provider.

Response has been significant from area lodging, with seven (7) facilities currently partnering with the Foundation and providing services ranging from deeply discounted rates to as many free rooms as are needed (contingent upon facility availability). Lodging availability will be an issue during peak season months of July-October.

Housing is crucial:

- During 2013, 520 nights housing was provided to 56 patients in Missoula+
- Chemotherapy treatment duration is 3 days, requiring patients to stay in Missoula for 3 nights
  - from July-December 2014, it is anticipated there will be a total of 50 chemotherapy patients for a total of 150 nights
- When Radiation opens during July, it is anticipated approximately 25% of chemotherapy patients will move on to receive Radiation
  - radiation treatment duration is 4 days/week for a total of 6 weeks
  - it is estimated 312 nights lodging will be needed from July-December 2014.
  - volumes anticipated to 50% chemotherapy patients will move on to receive radiation during 2015, following opening of Radiation and the addition of another physician

+ Numbers provided by The American Cancer Society Call Center. 75% are attributed to Community Medical Center

## II. PROPOSAL

This proposal seeks the following:

A. HOUSING FUNDS

Funds to add 10,000 square feet to the existing Ronald McDonald House structure.

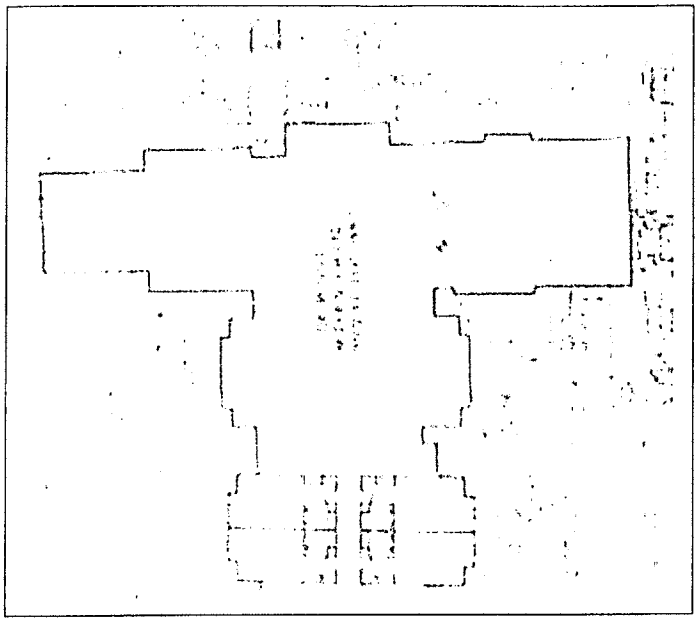
Funds would be gifted to the Ronald McDonald House and lodging would be provided to Community Medical Center through a lease agreement.

B. PATIENT AFFORDABILITY FUNDS+

Funds to permanently endow Patient Affordability.

+ Dollar Limit to be Defined

## III. HOUSING PLAN



The additional rooms at the Ronald McDonald House would be defined space exclusively for use by patients and one care provider who access services at Community Cancer Care. The space would also provide benefit to Ronald McDonald House families in the case of overflow.

The 16 rooms will each contain a small refrigerator, microwave, living room furniture, television, two queen beds, and a private bathroom. Use of the facility's common kitchen, living room, laundry, and library would be available to the guests.

Patients would work with the Social Worker at Community Cancer Care, to complete an application, documenting they meet criteria and to provide required information. Guests could stay for the duration of their treatment, depending on need, length of treatment, and availability of rooms.

Once registered, guests could come and go as they please. A Ronald McDonald House staff member would be onsite 24-hours a day. The facility would be open 24-hours a day, seven days a week, and 365 days a year. Cleaning, security, and other applicable staffing would be provided by Ronald McDonald House.

## IV. PATIENT AFFORDABILITY PLAN

A permanent Patient Affordability endowment would provide patients with crucial assistance to support items that are not covered under the hospital's "Patient Affordability" policy and could provide crucial support in the following areas:

- Assistance with medical bills for patients who do not qualify for support through the hospital's affordability program
- Help to pay for fuel to travel to and from frequent treatments
- Pay for utility bills and other everyday expenses
- Lodging for patient and care provider

## IV. BUDGET

### A. HOUSING

The estimated budget for housing is $2M.

### B. PATIENT AFFORDABILITY

$250,000 is requested to permanently endow Patient Affordability.

- 27 patients @ $500/each annually; or
- 54 patients $ $250/each annually

# EXHIBIT 12-A

## Robert Phillips

**From:** Robert J. Phillips
**Sent:** Thursday, April 24, 2014 3:48 PM
**To:** 'Scott Hacker'; Carlson, Stephen (scarlson@communitymed.org); Scott Stearns (sstearns@boonekarlberg.com)
**Subject:** CMC/CMCF considerations.

I told Scott H that I'd started a list of things that our current board needs to figure out, things that won't be handled in the sale transaction. Here is a start.

Glossary of terms:

CMC Corp.-- this is the current operating entity that owns and runs the hospital. It is the seller to RC/BC.

CMCF-- this is the current foundation.

NEWCO-- this is the proposed new foundation to be created to receive and disburse the sales proceeds.

We should consider leaving the CMC Corporation in place to hold a few assets. It will hold the D and O policy and the Medical malpractice tail. It could be the Entity to enforce agreement with RC. It could also handle liabilities that come up, and maintain a holdback for unforeseen expenses (Rabbi Trust). We should decide who will stay on that board. It should have enough money to hire an attorney if needed, and an accountant. We could agree to pay the directors, we should not need more than 2 or 3. It could do what was needed and when it was fairly certain that it was no longer needed, the balance of any funds could be distributed to whatever the hospital initially did with the proceeds of the sale. The hospital would not need to change its mission, so long as it is just in the winding up process. It will have to change its name, because RC/BC wants to use the name Community Medical Center.

The decision needs to be made whether CMCF will be merged with the new foundation if one is created. Benefits of keeping itself separated are that it'd be insulated from CMC liability. Staying separate means it could retain current board. It would need to change its mission and purpose, which now provides that it supports Community Hospital. It will have to change its name as the current facility will retain CMC, owned by RC/BC joint venture. It could perform any charitable purpose related to improvement of health in the region. It'd have to notify its donors of its new mission, and find out how to honor donor intent or restrictions. Benefits of joining NEWCO are not many, but it would mean that the CMCF would be along for the ride with NEWCO. That would make it part of something quite big.

Will there be a NEWCO? The sales proceeds will go to CMC Corp., which will have to transfer those assets to a foundation, either existing or a new one. Whichever it is, it will have to be a 501c3 organization, or qualify to become one. We already have two such organizations, CMCF and CMC Corp. If the proceeds were to be given to some other foundation, already in existence, then there need be no NEWCO. If, for instance, the proceeds were paid over to the University of Montana Foundation, for a restricted use, Health related education and Research, for instance, then there is no purpose for a NEWCO. The proceeds could go to the American Cancer Society, or Red Cross as well although I'd worry about those entities using the funds locally. The Attorney General has said that there should be a new board overseeing the disbursement of the sales proceeds, and if that is to be the rule, then neither CMCF or CMC Corp could hold the funds.

Regarding the Rabbi Trust, I suggest that the funds could be held in CMC Corp. I'd suggest 3-5 Million dollars would be appropriate. This entity would have the duty to enforce the agreement with RC/BC which could be expensive. It could continue to administer the 403b

plan, which needs to be held by a not for profit. It could make sure the tail policies are in effect and could respond to any claim against the indemnity agreement between it and RC/BC. If it does not continue to exist, we need to figure out what to do with the 403b.

The 401k plan and the health plan could both go to RC/BC.

Everything else should be taken care of in the sale transaction, like the joint ventures, assignment of any contracts, leases etc. We should not have to mess with those things.

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# EXHIBIT 12-B

## Robert Phillips

**From:** Robert Phillips
**Sent:** Tuesday, January 27, 2015 4:48 PM
**To:** Robert Phillips
**Subject:** Criteria from our July 2, 2014 meeting.

Email to Board Leadership:
Scott (Hacker) and I met this morning (July 2, 2014) and came up with a list of criteria by which we think the two competing proposals (newco vs. existing foundation) should be evaluated. These are general topics although we discussed them to the point that we understood what each of us meant by the rather short label. I send this to board leadership so you can see where we are, but it is a work in process and Scott (Hacker) has not seen this list. It is subject to refinement and fleshing out before useful.

1. Timing-- by this we mean how long would initial startup take before funds could be used to further our mission?
2. Cost-- What would the initial start up cost from the proceeds.
3. Control-- To what extent would current board have input/control over future use of funds, or if not control, how could it ensure compliance with terms of a grant?
4. Expertise-- to what extent does the current board have the expertise, if needed, to provide such control or input?
5. Politics-- How would the proposed use of funds be seen by regulators and the community?
6. Mission--to what extent does the model define the use of funds-- and what are the purposes of gifts.
7. Enforcement-- How would we make certain that the funds are used in accord with CMC mission going forward?
8. Review and accountability-- What is the Review and Accountability for the investment and use of the sales proceeds under each model?
9. Endowment model vs. Ability to make Capital expenditures. To what extent does the model anticipate using more than income of the corpus, and what does that mean?
10. Fundraising ability (matching funds availability, ongoing fundraising effort)
11. Miscellaneous issues--
    a. Effect on CMCF future-- could the current Foundation take part or not?
    b. Effect on ability to hold 2% ownership if CMC so elects. What entity could hold the 2% if the Board elects to do so?
    c. Effect on right to appoint members to Advisory Board of Joint venture and Billings Clinic Board. Does the model effect whether or who could appoint members to the RC joint venture, Billings Clinic board or other powers of appointment we (CMC) might have?

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